# Permission Form (Optional)

***If you want someone else to be given information about your Basic Health account, or help with your application or future changes to your account, please complete, sign, and date this form.*** You can:

- Use the form now by attaching it to your application and returning it in the envelope provided; **or**
- Fill out and mail the form to Basic Health, P.O. Box 42683, Olympia, WA 98504-2683 at any time in the future.

The permission will be in effect until you leave Basic Health or tell us to cancel it.

◄ Please detach at perforation ◄

## TO: BASIC HEALTH

I give my permission to the person(s) named below to act as my and / or my family's representative in the preparation and submission of this application and future changes to my Basic Health account.

I also give permission to Basic Health to release to the person(s) listed below the information necessary for processing my application, enrollment, and / or future changes to my Basic Health account. I understand that by signing this form I have not authorized the release or sharing of my health information. This permission will continue as long as I am enrolled in Basic Health unless I notify Basic Health that it is cancelled.

**Applicant's name** (please print): _____

**Applicant's social security number** (voluntary)
(**OR subscriber I.D. number, once assigned**,
if different than social security number): _____

| **Name(s) of person(s)/representative(s)** given permission to access account: | **Relationship to applicant OR name of organization** (list phone or fax number): |
|---|---|
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| | |

**X** _____ _____
Applicant's signature Date

Washington State law may require disclosure of any information you submit as a public record. The Health Care Authority's (the agency that administers Basic Health) Privacy Notice is available upon request by calling 360-923-2822 or online at www.basichealth.hca.wa.gov.

**This form will not be used for Basic Health *Plus* or the Maternity Benefits Program.**